University Hospitals

January 27, 2014

Frank Miller
3770 Covington Road
South Euclid, OH 44121

Re: Short Term Disability Claim Application

Dear Frank:

We are in receipt of your request for short term disability benefits submitted by you or on your behalf. We have received your Short Term Disability (STD) Claim Form and Authorization for Release of Medical Information.

Please be advised that the Family Medical Leave of Absence (FMLA) is a separate program from Short Term Disability (STD). **STD forms and documentation differ from FMLA.**

We have requested medical documentation from the physician noted on your STD Claim Form. Please follow up with your physician to assure they respond to our request in a timely manner. This will help us evaluate your claim quickly and thoroughly, and ensure that your benefits are paid timely. The requested medical documentation must be returned to us before we can continue processing your claim.

This supporting information may include:

- Medical examination findings
- Test results
- X-ray results
- Progress notes
- Hospital admission/discharge summaries
- Observation of anatomical, physiological or psychological abnormalities
- Return to work status

If this is a maternity claim, please contact Miriam Davis at 216-767-8244 when you deliver to initiate your benefits.

Pain, without medical findings to support your disability, is not proof of disability. Should you require an extension, beyond your initial request, and are not able to work on or before the authorization end date, it is your responsibility to ensure that you and/or your health care provider submit additional objective medical documentation to us supporting your extended disability request.

It is ultimately your responsibility to ensure that we receive all of the necessary information in order to process your claim and pay short term disability benefits.

If you have any questions, do not hesitate to contact this office at 216.767.8531.

Sincerely,

Debbie Rogers

Debbie Rogers
Claims Administrator
Disability Management Services

(A)

Disability Management Services
UH Management Services Center 3605 Warrensville Center Road, MS: MSC 9140, Shaker Heights, OH 44122
Phone 216-767-8531 ~ 866-RTW- UHCH (866-789-8424) Fax 216-201-4636

University Hospitals

RECEIVED JAN 27 2014

Should be 2015

THIS FORM IS TO BE COMPLETED AND SIGNED BY THE EMPLOYEE
Please Return this completed form to UH Disability Management Services.
Confidential Fax: 216-201-5464
(We will submit a request to your physician for medical documentation)

SHORT TERM DISABILITY CLAIM FORM AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Employee Information

Entity: CMC (CMC, ELYRIA, UHMG, UHMSO, Etc.) Department/Position: Diversity/Admin Asst II Hire Date: 5-16-2002

Name: Miller (Last) JR. FRANK (First) (MI)

Home Address: 3770 Covington Road

City: South Euclid State: Ohio Zip: 44121

Home Phone ( ) Cell Phone (216) 543-3949 Work Phone (216) 844-4717

Gender: M Date of Birth: 12/06/1956 (MM/DD/YYYY) Social Security #: 297-68-8410 (XXX-XX-XXXX)

Primary Care Physician: Pecl Silver/cog Office Phone: 791-3800-1020 Office Fax:

Permission to leave Protected Health Information on Answering Machine/Voice Mail ☐ YES ☑ NO

Claim Information and Physician Information

Is this claim: ☑ A Work Related Injury ☐ An Extension of a Previous Claim ☑ An Original Claim

Primary Diagnosis: Carpal Tunnel Syndrome

Physician Who Advised You Off Work: Effective Date: 1-16-2015

Office Address: 10701 East Boulevard City: Cleveland State: OH Zip: 44106

Office Phone Number: 216-791-3800 Ext 1020 Office Fax Number:

First day of Total Disability: 1-16-2015 Return to Work Date (If known):

I, the undersigned, authorize my treating physician/provider and/or treating facility and its employees to release information from my medical records to University Hospitals employees for the purposes of considering Short Term Disability benefits and/or FMLA certification. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **I understand, if I fail to specify an expiration date this authorization will expire in one year.**

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization. I understand there may be charges for the copying and release of information and accept financial responsibility.

X _____ 1, 23, 2015
Signature of Patient/Legal Representative* Date Signed

_____ ☐ Patient unable to sign
Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable

*If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.

(A-1)

from performing some, but not all, of the essential duties of your or any occupation, and as a result, your Current Weekly Earnings are more than 20% but no more than 80% of your pre-disability Weekly Earnings.

Sickness vs. Accident
A Disability shall be deemed to be caused by sickness, and not by accident, if:

1. It is caused or contributed to by:
    a) any condition, disease or disorder of the body or mind;
    b) any infection, except a pus-forming infection of an accidental cut or wound;
    c) hernia of any type unless it is the immediate result of an accidental injury covered by this plan;
    d) any disease of the heart;
    e) Mental Illness;
    f) Substance Abuse;
    g) pregnancy;
    h) any medical treatment for items (a) through (g) above; or
2. It is caused directly or indirectly by accident, but commences more than 30 days after the date of the accident.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1. impairments in social and/or occupational functioning;
2. debilitating physical condition;
3. inability to abstain from or reduce consumption of the substance; or
4. the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

Total Disability or Totally Disabled means that you are prevented by:

1. accidental bodily injury;
2. sickness;
3. Mental Illness;
4. Substance Abuse; or
5. pregnancy,

from performing the essential duties of your occupation, and as a result, you are earning less than 20% of your pre-disability Weekly Earnings.

We, us or our means the University Hospitals Health System, Inc.

Weekly Earnings means your usual weekly rate of pay from the Employer, not counting:

1. commissions;
2. bonuses;
3. overtime pay; or
4. any other fringe benefit or extra compensation.

If you become Disabled, your Weekly Earnings will be the rate in effect on your last day as an Active Full-time Employee before becoming Totally Disabled.

You or your means the employee covered by the program.

Attachment A

First Report of Injury/Employee Incident Report (cont.)

University Hospitals

POLICY# 20002007

FIRST REPORT OF INJURY • EMPLOYEE INCIDENT REPORT

REPORT Injury to Worker's Comp Services @ 216.767-8700

☐ Bedford Medical Center ☐ Geauga Medical Center ☐ UH Extended Care Campus ☐ UHMG/UHMP ☐ UH CMC Building/Location: MAY
☐ Conneaut Medical Center ☐ Geneva Medical Center ☐ Richmond Medical Center ☐ UH Homecare Other Entity:

EMPLOYEE

LAST Name: MILLICER SR		FIRST Name: FRANK	
Soc Sec #: 124 16 8811 0	Date of Birth: 12/06/1956	☐ Male ☐ Female	Home Phone #: (216) 543-3949
Address: 3770 Commerton Road		City/ Zip Code: South Euclid, 44121-1952	
Hire Date: mo 3 yr 91	Department: Mission Facility Rec	Position/ Title: Admin Asst	Shift: DAY
Employee Status: ☐ FT ☐ PT ☐ PRN ☐ TEMP ☐ Attending ☐ Student ☐ POV ☐ Other		Normal Scheduled Work Days: (Indicate Number of Hours Each Day) ( ) Sun (8.5) Mon (8.5) Tue (8.5) Wed (8.5) Thur (8.5) Fri ( ) Sat	Work #: 216-844-4772 Pager #:

INCIDENT

DATE of Occurrence: 12/19/14	TIME: : ☐ AM ☐ PM	NAME of Supervisor: Frankland	DATE & TIME Notified: 1/18/15 6:00 ☐ AM ☐ PM
Was occurrence on Employer's premises? ☒ Yes ☐ No If NO, explain:		Phase of employee workday at time of occurrence? (Mark ALL that apply) ☐ Meal Break ☐ Enter/Leave Work ☐ Driving ☐ Overtime ☐ Work ☐ Rest Break ☐ Other:	
LOCATION of Occurrence: ☐ Field Service ☐ Garage/Lot ☒ Office ☐ Off-Site ☐ Patient Care area ☐ Resident Service ☐ Subsidiary Location ☐ Other:			
SPECIFIC Area: ☐ Elevator # ☐ Hall area - flr ☐ Lab - rm ☐ Nurse Station ☐ Office # ☐ Pt's room # ☐ Stairwell ☐ Other (describe):			

INJURY

① Use the reverse side of this sheet for the Numeric Code(s):

# #	Code	Details/Description (if applicable):
24	CAUSE	Repeated Motion
21	CAUSE	Strain Material Handling

② Use the reverse side of this sheet for the Alpha-Code(s):

Letters		Details/Description (if applicable):
FG	BODY PART(S) OR AREA ☐ Left ☒ Right	Thumb middle fingers
HW	☐ Left ☒ Right	Hand
RS	☐ Left ☒ Right	Wrist
AK	☐ Left ☒ Right	Forearm

Is this a ☒ NEW INJURY, or a ☐ REINJURY? If reinjury, date of original injury? ___(mo)___(yr)

Where did you seek medical treatment? ☐ Corporate Health Dept. ☐ Emergency Dept. ☐ OTHER Facility (name, address & ph#) Lou's Stokes Vamc

PPE

Was Personal Protective Equipment (PPE) used? ☐ Yes ☒ No If Yes, select item(s) used: ☐ Face Shield ☐ Safety Glasses/Goggles ☐ Gloves ☐ Gown ☐ Head Cover ☐ Safety Shoes ☐ Respirator/Mask ☐ Other:

NARRATIVE

Please answer each question below. Include details such as use of tools, equipment, materials, patient handling, what you were doing and where.

Describe where (location) your injury/near miss took place?
Work space

Identify any tools, equipment or materials you were using or carrying at the time of the injury/near miss? ☐ N/A
Computer

Describe step by step: the events that led up to the injury/near miss?
Typing, Lifting

What do you think caused the accident?
Repetative motion

List the Names of all WITNESSES. Indicate whether (C) Co-worker, (E) UHHS Employee, or (O) Other (ex., visitor, patient, etc).
☐ C ☐ E ☐ O _____ (phone) _____ ☐ C ☐ E ☐ O _____ (ph#) _____
☐ C ☐ E ☐ O _____ (phone) _____ ☐ C ☐ E ☐ O _____ (ph#) _____

Employee Signature: _____ Date: 1-23-2015

I certify by my signature the information on this injury report is true and complete to the best of my knowledge.

Employee Signature _____ Date 1-23-2015

This is my description of the account. As provided by Section 4123.651 of the Ohio Revised Code, I hereby permit the release of medical information, records and reports necessary for the administration of my workers' compensation claim to the Industrial Commission of Ohio, the Bureau of Workers' Compensation, their authorized representatives and this hospital. Information, records and reports may possibly pertain to a condition other than or aggravated by my claim or to consider payment or to determine the eligibility of, payment of compensation and medical benefits under any workers' compensation claim. A copy shall be as good as the original.

REPORT MUST BE SIGNED TWICE: ONE SIGNATURE TO DESCRIBE OCCURRENCE AND ONE SIGNATURE TO AUTHORIZE RELEASE OF MEDICAL INFORMATION.

Fax to: Workers' Compensation Services Department 216.767-8277

(A-2)

University Hospitals

March 20, 2015

Frank Miller
3770 Covington Rd.
South Euclid, OH 44121

RE: **YOUR WORKERS' COMPENSATION CLAIM**
Date of Injury: 12/19/14
Claim Number: 14-870054
Employer: University Hospitals

Dear Mr. Miller:

We have received an incident report stating that you were injured on the job. To properly process your claim, the attached **two forms** need to be completed by you and returned to my attention as promptly as possible.

UH Disability Management Services
Mail Stop – MSC 9140
3605 Warrensville Center Road
Shaker Hts., OH 44122

Approval of your claim will be delayed until all forms are received. **Please list the medical providers involved in your treatment (at any time) for the body part(s) listed in the claim.**

If you should have any questions, please do not hesitate to contact this office at (216) 767-8700. Thank you in advance for your anticipated cooperation in this matter.

Sincerely,

Lynette Stover
Senior Claims Administrator
UH Disability Management Services

Enclosure(s)

Cc: file
BWC

(A-3)

University Hospitals

Claimant: Frank Miller
Claim Number: 14-870054
Date of Injury: 12/19/14
Employer: University Hospitals

LIST OF MEDICAL PROVIDERS

Please list all doctors you have treated with, currently and at any time prior to this injury, for complaints or symptoms relating to your injury. This information must be returned to this office as soon as possible. Failure to respond may delay processing of your claim. If more space is necessary, please use separate sheet.

Name: _____ Address: _____
Phone Number: _____ _____

Name: _____ Address: _____
Phone Number: _____ _____

Name: _____ Address: _____
Phone Number: _____ _____

Name: _____ Address: _____
Phone Number: _____ _____

Name: _____ Address: _____
Phone Number: _____ _____

Name: _____ Address: _____
Phone Number: _____ _____

Name: _____ Address: _____
Phone Number: _____ _____

Return To:
UH Disability Management Services
Mail Stop - MSC 9140
3605 Warrensville Center Road
Shaker Hts., OH 44122

University Hospitals

Claimant: Frank Miller
Claim Number: 14-870054
Date of Injury: 12/19/14
Employer: University Hospitals

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Claimant: Miller Frank
Last Name First Name Middle Name

To Whom It May Concern:

This is to authorize any physician, hospital medical attendant, nurse, technician or others to furnish our authorized and designated represent and/or the Employer, all records, opinions, reports, x-rays, photo static copies, abstracts or excerpts of any records or any other information or document they may request that you may have in your custody or under your control regarding the patient who name appears above.

A photocopy of this release is as valid as the original.

Please list medical providers and addresses from which you have sought medical treatment for this condition.

As provided by Section 4123.651© of the Ohio Revised Code, I hereby permit the release of medical information, records and reports, relative to the issues necessary for the administration of my workers' compensation claim to the Industrial Commission of Ohio, Ohio Bureau of Workers' Compensation, or the employer, as such medical information, records and reports pertain to a condition either allowed or requested in my claim, or to consider the payment or to determine the eligibility of payment of compensation and medical benefits under my workers' compensation claim.

Signature of Claimant

3-27-2018
Date

(A-4)

UH Disability Management Services • MSC 9140 • 3605 Warrensville Center Road • Shaker Hts., OH 44122
Phone (216) 767-8700 • Fax (216) 767-8277

University Hospitals

Claimant: Frank Miller
Claim Number: 14-870054
Date of Injury: 12/19/14
Employer: University Hospitals

LIST OF MEDICAL PROVIDERS

Please list all doctors you have treated with, currently and at any time prior to this injury, for complaints or symptoms relating to your injury. This information must be returned to this office as soon as possible. Failure to respond may delay processing of your claim. If more space is necessary, please use separate sheet.

Name: DANiel TRAN MD Address: Louis Stokes Cleveland VA Medical Center
Phone Number: 216-791-3800 10701 East Boulevard, Cleveland OH 44106

Name: Joseph Sheeba MD Address: Louis Stokes Cleveland VA Medical Center
Phone Number: 216-791-3800 10701 East Boulevard, Cleveland OH 44106

Name: Sophia Trifica MD Address: Louis Stokes Cleveland VA Medical Center
Phone Number: 216 791-2800 10701 East Boulevard, Cleveland, OH 44106

Name: Ahmad Tarek Chami MD Address: Louis Stokes Cleveland VA Medical Center
Phone Number: 216-791-3800 10701 East Boulevard, Cleveland OH 44106

Name: Dr Mark Ley Address: Louis Stokes Cleveland VA Medical Center
Phone Number: 216 791 3800 10701 East Boulevard Cleveland OH 44106

Name: Sally Nahbodiri MD Address: Louis Stokes Cleveland VA Medical Center
Phone Number: 216 791 3800 10701 East Boulevard Cleveland OH 44106

Name: Conner, Sujeeth MD Address: Louis Stokes Cleveland VA Medical Center
Phone Number: 216 791 3800 10701 East Boulevard Cleveland OH 44106

Return To:
UH Disability Management Services
Mail Stop - MSC 9140
3605 Warrensville Center Road
Shaker Hts., OH 44122

University Hospitals

Claimant: Frank Miller
Claim Number: 14-870054
Date of Injury: 12/19/14
Employer: University Hospitals

LIST OF MEDICAL PROVIDERS

Please list all doctors you have treated with, currently and at any time prior to this injury, for complaints or symptoms relating to your injury. This information must be returned to this office as soon as possible. Failure to respond may delay processing of your claim. If more space is necessary, please use separate sheet.

Name: DANiel TRAN MD
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Address: Louis Stokes Cleveland VA Medical Center 10701 East Boulevard, Cleveland OH 44106

Name: Joseph Sheeba MD
Phone Number: 216-791-3800
Address: Louis Stokes Cleveland VA Medical Center 10701 East Boulevard, Cleveland OH 44106

Name: Sophia Trifia MD
Phone Number: 216 791-2800
Address: Louis Stokes Cleveland VA Medical Center 10701 East Boulevard, Cleveland, OH 44106

Name: AHMAD TAREK Chami MD
Phone Number: 216-791-3800
Address: Louis Stokes Cleveland VA Medical Center 10701 East Boulevard, Cleveland OH 44106

Name: Dr MAKley
Phone Number: 216 791 3800
Address: Louis Stokes Cleveland VA Medical Center 10701 East Boulevard Cleveland OH 44106

Name: Sally Naeboodiri MD
Phone Number: 216 791 38002
Address: Louis Stokes Cleveland VA Medical Center 10701 East Boulevard Cleveland OH 44106

Name: COYNER, SNJEZANA MD
Phone Number: 216 791 3800
Address: Louis Stokes Cleveland VA Medical Center 10701 East Boulevard Cleveland OH 44106

Return To:
UH Disability Management Services
Mail Stop - MSC 9140
3605 Warrensville Center Road
Shaker Hts., OH 44122

(A-5)

University Hospitals

Claimant: Frank Miller
Claim Number: 14-870054
Date of Injury: 12/19/14
Employer: University Hospitals

LIST OF MEDICAL PROVIDERS

Please list all doctors you have treated with, currently and at any time prior to this injury, for complaints or symptoms relating to your injury. This information must be returned to this office as soon as possible. Failure to respond may delay processing of your claim. If more space is necessary, please use separate sheet.

Name: Qin, Angel M.D
Phone Number: 216 791 3800
Address: Louis Stokes Cleveland VA Medical Center 10701 East Boulevard Cleveland OH 44106

Name: Bauer Terry M.D
Phone Number: 216 791-3800
Address: Louis Stokes Cleveland VA Medical Center 10701 East Boulevard, Cleveland OH 44106

Name: Craig L. George M.D
Phone Number: 216 791 3800
Address: Louis Stokes Cleveland VA Medical Center 10701 East Boulevard Cleveland OH 44106

Name: Jenny Washington PA
Phone Number: 216 791 3800
Address: Louis Stokes Cleveland VA Medical Center 10701 East Boulevard Cleveland OH 44106

Name: _____
Phone Number: _____
Address: _____

Name: _____
Phone Number: _____
Address: _____

Name: _____
Phone Number: _____
Address: _____

Return To:
UH Disability Management Services
Mail Stop - MSC 9140
3605 Warrensville Center Road
Shaker Hts., OH 44122

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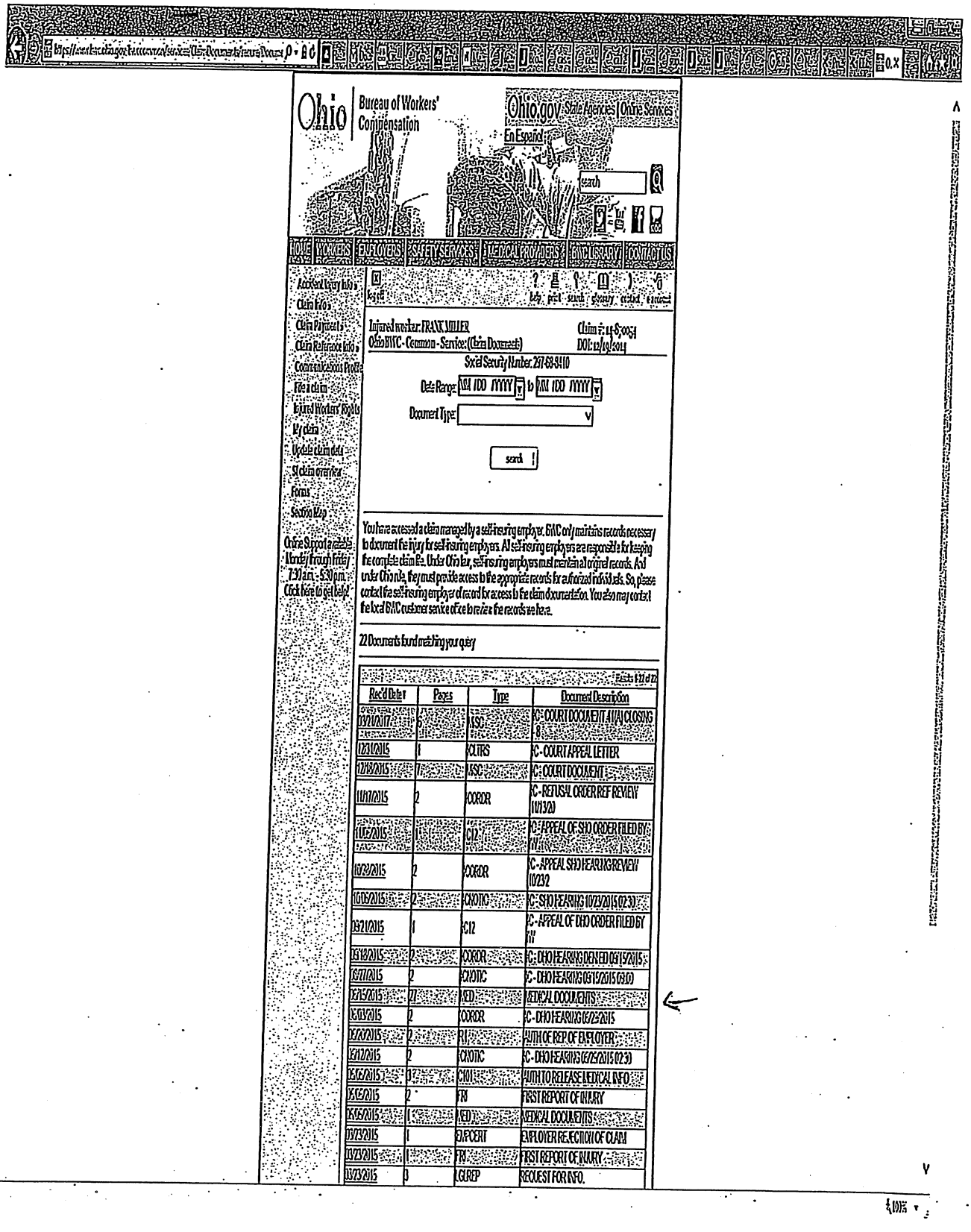

Ohio | Bureau of Workers' Compensation

Ohio.gov | State Agencies | Online Services

En Español

search

HOME | WORKERS | EMPLOYERS | SAFETY SERVICES | MEDICAL PROVIDERS | EMPLOYSURV | CONTACT US

Accident Injury Info
Claim Info
Claim Payments
Claim Reference Info
Communications Profile
File a claim
Injured Workers' Rights
My claim
Update claim data
Status overview
Forms
Section Map

Online Support available Monday through Friday 7:30 a.m. - 5:30 p.m. Click here to get help!

help | print | search | glossary | contact

Injured worker: FRANK MILLER — Claim #: 14-803541
Ohio BWC - Common - Service: (Claim Documents) — DOI: 12/19/2014
Social Security Number: 267-68-3410

Date Range: MM DD YYYY to MM DD YYYY

Document Type:

search

You have accessed a claim managed by a self-insuring employer. BWC only maintains records necessary to document the injury for self-insuring employers. All self-insuring employers are responsible for keeping the complete claim file. Under Ohio law, self-insuring employers must maintain all original records. And under Ohio law, they must provide access to the appropriate records for authorized individuals. So, please contact the self-insuring employer of record for access to the claim documentation. You also may contact the local BWC customer service office to review the records we have.

22 Documents found matching your query

Rec'd Date	Pages	Type	Document Description
03/21/2017	6	ASC	IC: COURT DOCUMENT AMA CLOSING
12/31/2015	1	COLTRS	IC - COURT APPEAL LETTER
12/18/2015	11	ASC	IC: COURT DOCUMENT
11/17/2015	2	CORROR	IC - REFUSAL ORDER REF REVIEW 10/13/20
11/05/2015	1	CIT	IC - APPEAL OF SHO ORDER FILED BY: IW
10/29/2015	2	CORROR	IC - APPEAL SHO HEARING REVIEW 10/23/2
10/15/2015	2	CRXOTIC	IC: SHO HEARING 10/23/2015 (0:23)
09/21/2015	1	CIT2	IC - APPEAL OF DHO ORDER FILED BY IW
09/18/2015	2	CORROR	IC: DHO HEARING DENIED 09/15/2015
09/17/2015	2	CRXOTIC	IC - DHO HEARING 09/15/2015 (3:30)
08/25/2015	77	MED	MEDICAL DOCUMENTS
08/03/2015	2	CORROR	IC - DHO HEARING 08/25/2015
07/27/2015	2	RI	AUTH OF REP OF EMPLOYER
07/17/2015	2	CRXOTIC	IC - DHO HEARING 08/25/2015 (2:3)
06/26/2015	3	CM01	AUTH TO RELEASE MEDICAL INFO
06/16/2015	2	FRI	FIRST REPORT OF INJURY
06/16/2015	1	MED	MEDICAL DOCUMENTS
05/23/2015	1	EMPCERT	EMPLOYER REJECTION OF CLAIM
05/23/2015	1	FRI	FIRST REPORT OF INJURY
05/23/2015	0	LGLREP	REQUEST FOR INFO.

27 MEDICAL DOCUMENTS

(A-7)

University Hospitals

ATTENDING PHYSICIAN STATEMENT (APS)
SHORT TERM DISABILITY CLAIM INFORMATION

INSTRUCTIONS

This report must be completed by the attending physician to assist us in making a disability determination.

If this claim is related to a pregnancy, please complete the pregnancy section ONLY, sign and date the form.

For all other conditions, please complete all applicable sections of this form, sign and date. Attach supporting documentation such as office notes, medical records, consultations and/or testing reports.

THIS FORM MUST BE SIGNED AND DATED BY THE PHYSICIAN.

PLEASE COMPLETE AND RETURN TO CONFIDENTIAL FAX:

216-201-5464

CLAIMANT INFORMATION

aimant lame: FRANK MILLER	Home Phone Number	Birth Date: 12/06/1956

PREGNANCY

ected Delivery Date:	Actual Delivery Date:	Type of Delivery: • Vaginal • C-Section
e First Unable to Work:	Date Hospitalized:	
regnancy nplications? • Yes • No	If there are any pregnancy complications, be sure to include prenatal records when submitting this form.	

ALL OTHER CONDITIONS

ght	Weight	Date of first visit regarding current conditions:
e patient ceased work because of condition: 1/16/15		Did you advise patient to cease work? • Yes • No If yes, when?
the patient been treated for the same/similar dition in the past?	• Yes (•) No If yes, when?	see below
s, please describe ED 12/[illegible]/14 ; 1/16/2015		
ne patient's condition due to injury or sickness involving the patient's employment?	• Yes • No • Unknown	

mary Diagnosis and Treatment

t is the primary diagnosis preventing your patient from working? Please include Primary ICD — 9 and/or DSM IV Multi-Axial Diagnoses and Codes

(R) carpal tunnel syndrome

of last examination

ribe Subjective Symptoms pain, numbness right hand

University Hospitals

ATTENDING PHYSICIAN STATEMENT (APS)
SHORT TERM DISABILITY CLAIM INFORMATION

ALL OTHER CONDITIONS CONT.

Describe Objective Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.)

EMG 3/23/2015 (R) CTR 10/15/15

Other Conditions (Please attach additional information as necessary)

Are there other conditions that prevent your patient from working? If so, please list with information as follows:

Secondary ICD-9s Diagnosis

Secondary ICD-9s Diagnosis

Describe Subjective Symptoms

See 1st page

Describe Objective Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.)

moderate right CTS affecting sensory and motor components

Treatment Plan

Describe the patient's current treatment plan (please include facility name and address):

SIP carpal tunnel release 10/15/2015 CCF

Medications (Please list all medications including dosage and frequency)

Has the claimant been hospitalized? • Yes • (No) Date(s) Hospitalized: From To

Has surgery been performed? (Yes) • No Date Surgery Performed: 10/15/15

Surgical Procedure:

Other Providers: Please supply complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #	Fax #	Treatment From	Treatment To

RETURN TO WORK

Expected Return to Work Date: 10/26/2015 • Full Time • Part Time

Restrictions and/or physical limitations:

no push pull lifting with right hand

Duration (dates) of Restrictions and/or Physical Limitations: From To

FRAUD NOTICE:

Any person who knowingly files a statement of claim containing false or misleading Information is subject to criminal and civil penalties.

Print or Type Name: Sally Nambudiri | Medical Specialty: Internal medicine

Street Address: 10701 East Blvd | Telephone Number: (216) 791-3800

City: Cleveland | State: OH | ZIP Code: 44106 | Fax: (216) 707-5959

Signature of Physician: [signature] | Date: 10/30/15

University Hospitals

ATTENDING PHYSICIAN STATEMENT (APS)
SHORT TERM DISABILITY CLAIM INFORMATION

INSTRUCTIONS

This report must be completed by the attending physician to assist us in making a disability determination.

If this claim is related to a pregnancy, please complete the pregnancy section ONLY, sign and date the form.

For all other conditions, please complete all applicable sections of this form, sign and date. Attach supporting documentation such as office notes, medical records, consultations and/or testing reports.

THIS FORM MUST BE SIGNED AND DATED BY THE PHYSICIAN.

PLEASE COMPLETE AND RETURN TO CONFIDENTIAL FAX:

216-201-5464

CLAIMANT INFORMATION

Claimant Name: FRANK MILLER	Home Phone Number	Birth Date: 12/06/1956

PREGNANCY

Expected Delivery Date:	Actual Delivery Date:	Type of Delivery: · Vaginal · C-Section
Date First Unable to Work:	Date Hospitalized:	
Pregnancy Complications? · Yes · No	If there are any pregnancy complications, be sure to include prenatal records when submitting this form.	

ALL OTHER CONDITIONS

Height	Weight	Date of first visit regarding current conditions: 6/23/15
Date patient ceased work because of condition:	Did you advise patient to cease work? (Yes) · No	If yes, when? 10/5/15
Has the patient been treated for the same/similar condition in the past? · Yes (No)	If yes, please describe	If yes, when?

Is the patient's condition due to injury or sickness involving the patient's employment? · Yes (No) · Unknown

Primary Diagnosis and Treatment

What is the primary diagnosis preventing your patient from working? Please include Primary ICD — 9 and/or DSM IV Multi-Axial Diagnoses and Codes

(R) CTS 354.0

Date of last examination 7/23/15

Describe Subjective Symptoms

SURGERY FOR CARPAL TUNNEL RELEASE 10/5/15

University Hospitals

ATTENDING PHYSICIAN STATEMENT (APS)
SHORT TERM DISABILITY CLAIM INFORMATION

ALL OTHER CONDITIONS CONT.

Describe Objective Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.)

S/P (R) CTR 10/5/15

Other Conditions (Please attach additional information as necessary)

Are there other conditions that prevent your patient from working? If so, please list with information as follows:

Secondary ICD-9s Diagnosis

Secondary ICD-9s Diagnosis

Describe Subjective Symptoms

Describe Objective Findings (MRIs, X-rays, EMG/NCV studies, Lab tests, clinical findings, GAF etc.)

Treatment Plan

Describe the patient's current treatment plan (please include facility name and address):

SURGERY 10/5/15

Medications (Please list all medications including dosage and frequency)

NONE / MOBIC / KEFLEX

Has the claimant been hospitalized? ·· Yes ·· No | Date(s) Hospitalized: From To

Has surgery been performed? ·· Yes ·· No | Date Surgery Performed: 10/5/15

Surgical Procedure:

(R) CTR

Other Providers: Please supply complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #	Fax #	Treatment From	Treatment To

RETURN TO WORK

Expected Return to Work Date: 10/26/15 ·· Full Time ·· Part Time

Restrictions and/or physical limitations:

NO LIFT/PUSH/PULL C (R) HAND

NO RESTRICTIONS AFTER 10/26/15

Duration (dates) of Restrictions and/or Physical Limitations: From To

FRAUD NOTICE:

Any person who knowingly files a statement of claim containing false or misleading Information is subject to criminal and civil penalties.

Print or Type Name: DR. WILLIAM SEITZ | Medical Specialty: ORTHOPAEDIC SURGERY

Street Address: 1730 W. 25 | City: CLEVELAND | State: OH | ZIP Code: 44113 | Telephone Number: (216) 363 2331 | Fax: (216) 696 2992

Signature of Physician | Date: 10/9/15

DISABILITY MANAGEMENT SERVICES
3605 WARRENSVILLE CENTER ROAD MSC 9140 SHAKER HEIGHTS, OHIO 44122 PHONE: 216.767.8700

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2. the required premium for You must be paid;
3. Your benefit level, or the amount of earnings upon which Your benefit may be based, will be that in effect on the day before said leave commenced; and
4. such continuation will cease immediately if one of the following events should occur:
    a) the leave terminates prior to the agreed upon date;
    b) the termination of the UHSTD Program;
    c) non-payment of premium when due;
    d) the UHSTD Program no longer covers Your class; or
    e) the date Your Employer ceases to be a Participant Employer, if applicable.

Does Your coverage continue while You are Disabled and no longer an Active Full-time Employee?
If You are no longer an Active Full-time Employee because You are Disabled, Your Short Term Disability Coverage will be continued:
1. while You remain Disabled; and
2. until the end of the period for which You are entitled to receive Short Term Disability Benefits.

After Short Term Disability benefit payments have ceased, Your coverage will be reinstated, provided:
1. You return to work for one full day as an Active Full-time Employee in an eligible class;
2. the UHSTD Program remains in force; and
3. the premiums for You were paid during Your Disability, and continue to be paid.

Do benefits continue if the UHSTD Program terminates?
If You are entitled to benefits while Disabled and the UHSTD Program terminates, benefits:
1. will continue as long as You remain Disabled by the same disabling condition; but
2. will not be provided beyond the date we would have ceased to pay benefits had the coverage remained in force.

Termination for any reason of the UHSTD Program will have no affect on our liability under this provision.

GENERAL PROVISIONS

What happens if facts are misstated?
If material facts about You were not stated accurately:
1. Your premium may be adjusted; and
2. the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement made by You relating to Your insurability will be used to contest the coverage for which the statement was made after the coverage has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

When should we be notified of a claim?
You must give us written notice of a claim within 30 days after Disability starts. If notice cannot be given within that time, it must be given as soon as reasonably possible. Such notice must include Your name and Your address.

Are special forms required to file a claim?
When we receive a notice of claim, You will be sent forms for providing us with proof of loss. We will send these forms within 15 days after receiving a notice of claim. If we do not send the forms within 15 days, You may submit any other written proof which fully describes the nature and extent of Your claim.

When must proof of loss be given?
Written proof of Your Disability must be sent to us within 90 days after the start of the period for which we owe payment. After that, we may require further written proof that You are still Disabled. If proof is not given by the time it is due, it will not affect the claim if:
1. it was not possible to give proof within the required time; and
2. proof is given as soon as reasonably possible; but
3. not later than 1 year after it is due, unless You are not legally competent.

We have the right to require, as part of the proof of loss:
1. Your signed statement identifying all Other Income Benefits; and
2. proof satisfactory to us that You and Your dependents have duly applied for all Other Income Benefits which are available.

May additional proof be required?
We may have you examined to determine if you are Disabled. Any such examination will be:
1. at our expense; and
2. as reasonably required by us.

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Active Full-time or Part-time Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. Such employee must work the number of hours in the Employer's normal work week. This must be at least the number of hours for Employment shown in the Schedule of Coverage. Except as otherwise indicated, the term Active Full-time Employee also includes part-time employees working the number of hours indicated in the Schedule of Coverage for part-time employment. Part-time employee does not include a temporary, leased or seasonal employee.

Actively at Work
You will be considered to be actively at work with the Employer on a day which is one of the Employer's scheduled work days if you are performing, in the usual way, all of the regular duties of your job on a Full-time basis on that day. You will be deemed to be actively at work on a day which is not one of the Employer's scheduled work days only if you were actively at work on the preceding scheduled work day. Except as otherwise indicated, for part-time employees the term Actively at Work also includes regular duties on a part-time basis.

Current Weekly Earnings means the Weekly Earnings you receive from any employer or for any work while Disabled and eligible for Residual Disability benefits under this plan.

Disability means Total or Residual Disability.

Disabled means Totally or Residually Disabled.

Employer means University Hospitals Health System, Inc.

Mental Illness means any psychological, behavioral or emotional disorder or ailment of the mind, including physical manifestations or psychological, behavioral or emotional disorders, but excluding demonstrable structural brain damage.

Other Income Benefits mean the amount of any benefit for loss of income, provided to you or to your family as a result of the period of Disability for which you are claiming benefits under this plan. This includes any such benefits for which you or your family are eligible, or that are paid to you, your family, or to a third party on your behalf. This includes the amount of any benefit for loss of income from:

1. the United States Social Security Act, the Civil Service Retirement System, the Railroad Retirement Act, the Jones Act, the Canada Pension Plan, the Quebec Pension Plan or similar plan or act that you, your spouse, or your children are eligible to receive because of your Disability;
2. any plan or arrangement of coverage, whether insured or not, as a result of employment by or association with the Employer, or as a result of membership in or association with any group, association, union or other organization;
3. the Veteran's Administration or any other foreign or domestic governmental agency for the same Disability;
4. any governmental law or program that provides disability or unemployment benefits as a result of your job with the Employer;
5. any temporary or permanent disability benefits under a workers' compensation law, occupational disease law, or similar law; or
6. individual insurance policy where the premium is wholly or partially paid by the Employer.

Other Income Benefits will also include the amount of any benefits for loss of income from:

1. the portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings; or
2. compulsory "no-fault" automobile insurance.

Any general increase in benefits required by law that you are entitled to receive under any Federal Law will not reduce the Short Term Disability Benefit payable for a period of Total Disability that began prior to the date of such increase.

If you are paid Other Income Benefits in a lump sum, we will pro-rate the lump sum:

1. over the period of time it would have been paid if not paid in a lump sum; or
2. if such period of time cannot be determined, over a period of 260 weeks.

Physician means any person who is licensed to practice allopathic or osteopathic medicine.

Prior Plan means the short term disability plan carried by the Employer on the day before the Plan Effective Date.

Residual Disability or Residually Disabled means that you are prevented by:

1. accidental bodily injury;
2. sickness;
3. Mental Illness;
4. Substance Abuse; or
5. pregnancy,

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from performing some, but not all, of the essential duties of your or any occupation, and as a result, your Current Weekly Earnings are more than 20% but no more than 80% of your pre-disability Weekly Earnings.

Sickness vs. Accident
A Disability shall be deemed to be caused by sickness, and not by accident, if:

1. It is caused or contributed to by:
    a) any condition, disease or disorder of the body or mind;
    b) any infection, except a pus-forming infection of an accidental cut or wound;
    c) hernia of any type unless it is the immediate result of an accidental injury covered by this plan;
    d) any disease of the heart;
    e) Mental Illness;
    f) Substance Abuse;
    g) pregnancy;
    h) any medical treatment for items (a) through (g) above; or
2. It is caused directly or indirectly by accident, but commences more than 30 days after the date of the accident.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1. impairments in social and/or occupational functioning;
2. debilitating physical condition;
3. inability to abstain from or reduce consumption of the substance; or
4. the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

Total Disability or Totally Disabled means that you are prevented by:

1. accidental bodily injury;
2. sickness;
3. Mental Illness;
4. Substance Abuse; or
5. pregnancy,

from performing the essential duties of your occupation, and as a result, you are earning less than 20% of your pre-disability Weekly Earnings.

We, us or **our** means the University Hospitals Health System, Inc.

Weekly Earnings means your usual weekly rate of pay from the Employer, not counting:

1. commissions;
2. bonuses;
3. overtime pay; or
4. any other fringe benefit or extra compensation.

If you become Disabled, your Weekly Earnings will be the rate in effect on your last day as an Active Full-time Employee before becoming Totally Disabled.

You or **your** means the employee covered by the program.

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